Medical Home Bonus Program V2.0

Revision History

Describes all updates made by the department to this document and the date those updates are effective.

Date Effective	Updated By	What Changed	Document Version
12/1/2013	IME	Initial Draft (10/22/2013)	1.0 DRAFT
12/1/2013	IME	Initial Draft (11/12/2013), clarified minimum member panel size to participate, clarified what populations are excluded from the baseline and quarterly performance reviews.	1.0 DRAFT
1/01/2014	IME	Finalized Document. Update the threshold to achieve the Wellness Exam Bonus to 50 percent	1.0
9/25/2014	IME	Expanded the definition of a Wellness Exam and made minor adjustements to the VIS Examples table	1.1
12/31/2014	IME	Added text to reflect Absolute Scoring methodology	2.0

For Participating Iowa Wellness Plan Providers and Medicaid Wellness Plan ACOs

The Value Index Score (VIS) Medical Home Bonus and the Wellness Exam Bonus are voluntary programs that support providers aimed at developing core medical home processes. The bonus programs work for providers operating within and outside of an Accountable Care Organization (ACO) delivery system by establishing a set of measures that accounts for variability in data for small practices and encourages providers towards efficiencies in health outcomes. The bonus program is exclusive to participating Iowa Wellness Plan providers and Iowa Wellness Plan ACOs under contract with the Iowa Department of Human Services. The Iowa Wellness Plan provides Medical coverage for adults, age 19-64 with income up to and including 100 percent of the Federal Poverty Level (FPL), that are not otherwise eligible for Medicaid services through the Medicaid State Plan.

The Department seeks to incent providers and ACOs that support organized delivery system reform. The VIS measure set is already utilized in Iowa's private sector. Aligning this set of measures for the Iowa Wellness Plan population in a no-risk environment is a building block to an ACO for the full Medicaid population in 2016. Both the VIS Medical Home Bonus and

Wellness Exam Bonus can be paid directly to participating Iowa Wellness Plan providers that are NOT associated with an Iowa Wellness Plan ACO. Participating Iowa Wellness Plan providers operating within an Iowa Wellness Plan ACO contract will have an aggregated bonus payment distributed to the ACO entity.

VIS Medical Home Bonus

The Department analyzes three years[1] of Medicaid claims data for each participating Iowa Wellness Plan provider. A VIS Baseline Percentage is established that represents their ranking on the VIS measure set for the network of participating providers.

To participate in the VIS Medical Home Bonus, the provider must have a minimum of 19 attributed[2] members on their panel, as well as a sufficient number of eligible panel members during the most recent 12 months prior to the performance period, to be scored on five of the six domains.

Each year, participating Iowa Wellness Plan providers are placed into quintiles and assigned a Target Improvement Goal. Participating Iowa Wellness Plan providers must improve their baseline percentage to the Target Improvement Goal to earn the full VIS Medical Home Bonus.

Starting in 2015, the IME will use an absolute scoring methodology that compares the providers improvement to their individual baseline score as opposed to their improvement relative to the overall network.

Quintile	*Target Improvement Goal
Quintile 1 (top performers)	Must not go below their baseline score
Quintile 2	4% above baseline
Quintile 3	6% above baseline
Quintile 4	8% above baseline
Quintile 5 (lowest performers)	10% above baseline
*Risk Corridors, defined below are applied to account for variation in data due to calculation at the individual provider level.	

At the end of each calendar quarter, participating Iowa Wellness Plan providers are measured against their Target Improvement Goal to establish if a VIS Medical Home Bonus has been earned. For those participating Iowa Wellness Plan providers contracted with an Iowa Wellness Plan ACO, bonuses will be awarded at the PCP level and added together to determine a payout to the ACO. Individual provider outcomes that include details on each measure within the VIS will be available to both the providers and ACOs.

Participating Iowa Wellness Plan providers in quintiles 2, 3, 4 & 5 can earn a partial bonus payment (50 percent of payment) if their quarterly VIS percentage is greater than midpoint between the baseline and Target Improvement Goal.

[1] For each VIS calculation, three overlapping years of claims data is evaluated. The evaluation spans 14 months of consecutive data.

[2] The Attribution Methodology is defined further into this document.

Quarterly VIS Medical Home Bonus Schedule

Quarterly Evaluation Period	Claims Run-Off Period (90 days)	Analysis of Data (60 days)	Date of Provider/ACO Notice and Payment of Results)
1st Quarter January to March	June 30	August 31	November
2nd Quarter April to June	September 30	November 30	January 31,
3rd Quarter July to September	December 31	February 28	April 30
4th Quarter October to December	March 31	May 31	July 31
Note: Dates above that fall on a holiday or on a non-business day will be processed on the next following business day.			

Risk Corridors

Risk corridors are applied to participating Iowa Wellness Plan providers by reviewing the average panel size for the most recent 12 months prior to the beginning of the performance year. Corridors are established concurrently with the VIS Baseline Percentage.

*Panel Size	Risk Corridor
Less than 200 Medicaid Members attributed to Panel	+ 4%
200 or more Medicaid Members attributed to the Panel	+2%
***Provider must have at least two years of Medicaid claims experience**	

VIS Measure Domains

The VIS measures improvement in both system outcomes and member outcomes. The core attributes of the VIS align with the goals for the Iowa Wellness Plan population and are organized into six domains.

Person-Focused (rather than disease-focused)

VIS Domain – Primary & Secondary Prevention (Adult Screenings, Well Exams)

This domain measures the provider's performance on screening services designed for early detection or prevention of disease. These measures are drawn from the National Committee for Quality Assurance's (NCQA) Health care Effectiveness Data and Information Set (HEDIS), a tool used by more than 90 percent of America's health plans to measure performance.

- The primary prevention domain includes scores for:
  - Percent of the provider's pediatric well-visits for children 30 days to 15 months, and three years to six years
  - Percent of the provider's mammogram screening to applicable patient populations
  - Percent of the provider's colorectal cancer screening to eligible patient population

First Contact with Health Care System

VIS Domain – Tertiary Prevention (Ambulatory Care Sensitive Acute and ED rates)

In addition to primary and secondary prevention to help keep the population healthy, the Treo Value Index Score has a Tertiary Prevention Domain that evaluates the effectiveness of a provider in addressing "sick" care. This domain incorporates two measures: potentially preventable hospital admissions and hospital emergency room visits.

- The tertiary prevention domain includes:
  - Percent difference between the expected number of hospital admissions that are potentially preventable and the actual rate of the provider's population
  - Percent difference between the expected number of hospital emergency room visits that are potentially preventable and the rate of the provider's population

Comprehensive

VIS Domain – Disease Progression (Panel Chronic Disease Status and Severity Shifts)

One measure for determining providers' ability to deliver quality care is their ability to manage the health status of their patient panel from one time period to another. This domain of the Treo Value Index uses a risk-adjusted assessment of the percent difference between the expected rate of disease progression and the actual rate of the disease progression in the provider's patient panel.

- The population health status domain uses two metrics of disease progression:
  - Change in the number of chronic conditions
  - Change in the severity within the chronic conditions

VIS Domain – Chronic & Follow-up (30 day post D/C, Readmission Rates, Chronic Care Visits)

For members of the population who have chronic conditions, the Treo Value Index measures the processes and impact chronic and follow-up care.

- The chronic and follow-up care domain includes the following three measures:
  - Percent difference between the number of expected hospital readmissions that are potentially preventable and the provider's actual number of potentially preventable readmissions
  - Percent of the provider's panel that visited a physician office within 30 days post-discharge
  - Percent of the provider's panel with chronic disease that have three or more physician visits

Coordinates Care and the Transfer of Information

VIS Domain – Continuity of Care (COC, PCP Visit, Any MD Visits)

This domain measures the concentration and continuity of physician visits. The Continuity of Care Domain is associated with a number of positive outcomes, such as lower rates of hospitalization and readmissions, more efficient medical care, and higher patient satisfaction.

- Specifically, the continuity of care domain includes:
  - Percent difference between the expected continuity of care score for providers serving similar populations and the actual score for the provider's panel (as published by Bice, T. W., & Boxerman, s. b. (1977). a quantitative measure of continuity of care. Medical care, 15(4), 347-349)
  - Percent of the provider's panel visiting a primary care provider (PCP)
  - Percent of provider's panel that visit a physician during evaluation year

VIS Domain – Efficiency (Generic Rx, Potentially Preventable Ancillaries)

The Efficiency Domain examines the risk-adjusted rate of prescribing generic medications and the appropriate use of outpatient services for a physician's panel. The analysis of outpatient services examines potentially preventable ancillary services, such as high cost imaging, ordered by primary care physicians or specialists that may not typically provide useful information for diagnosis and treatment.

- Specifically, the efficiency domain examines:
  - Percent difference between a physician's risk-adjusted performance on potentially preventable services and the expected rate for a comparable population
  - Percent difference between a physician's risk-adjusted rate of prescribing generic drugs and the expected rate for a comparable population

Examples of VIS Medical Home Bonus Program

Provider	Panel Size	Risk Corridor	Baseline Percent	Quintile (1-5)	Target Improvement Goal	Target w/o risk corridor applied	To Get 50% of VIS Bonus w/ risk corridor applied	To Get Max VIS Bonus w/ risk corridor applied
Provider A	>200	2%	83%	1	baseline	83%	NA	81%
Provider B	<200	4%	83%	1	baseline	83%	NA	79%
Provider C	>200	2%	76%	2	4%	80%	76%	78%
Provider D	<200	4%	76%	2	4%	80%	74%	76%
Provider E	>200	2%	45%	3	6%	51%	46%	49%
Provider F	<200	4%	45%	3	6%	51%	44%	47%
Provider G	>200	2%	32%	4	8%	40%	34%	38%
Provider H	<200	4%	32%	4	8%	40%	32%	36%

Note: Providers in the top quintile are not eligible for a 50 percent VIS Bonus. They must maintain or improve their baseline VIS score to receive a bonus payment. A risk corridor still applies to providers in the top quintile,

Attribution Methodology

To establish VIS performance, members are attributed to participating Iowa Wellness Plan providers. Members include Iowa Wellness Plan members and Medicaid [3] members with at least 12 months of eligibility. The methodology allows the member to choose a PCP (through the Iowa Wellness Plan or through the MediPASS program). If a member does not have an assigned PCP, then the member is attributed using a methodology based on counting unique E/M visits to Iowa Wellness Plan providers. The member is assigned to the Iowa Wellness Plan provider with the highest number of unique visits. Attribution is calculated using the most recent 12 months of claims history for a member in order to attribute. If attribution cannot be determined based on the most recent 12 months, an additional 12 month look back is used.

Attribution is re-calculated quarterly for measuring VIS performance and monthly for updated dashboard results available to participating Iowa Wellness Plan providers.

[3] Medicaid members receiving Long Term Care in an institutional setting (NF/SNF),a Home and Community Based Services program, in an Residential Care Facility (RCF), receiving Hospice services, or identified as having a Serious and Persistent Mental Illness (SPMI) are not attributed to participating Iowa Wellness Providers for purpose of calculating the VIS measures.

Schedule of Annual Baseline Calculations

Performance Year	Baseline Year	Claims Run – off Period	Analysis	Provider ACO Notification
Calendar Year 2014 **(1/1/2014 – 12/31/2014)**	State Fiscal Year 2013 (7/1/2012 – 6/30/2013)	September 30	December – March	April 2014
CY 2015 **(1/1/2015 – 12/31/2015)**	SFY 2014 (7/1/2013 – 6/30/2014)	September 30	November 30	Febuary 15
CY 2016 **(1/1/2016 – 12/31/2016)**	SFY 2015 (7/1/2014 – 6/30/2015)	September 30	November 30	December 1

Provider/ACO notification of baseline results includes the following*:*

- Baseline percentage (ranking), Assigned Quintile, VIS Target Improvement Goal, and Assigned Risk Corridor

Within the 3M Treo online dashboard, providers have access to:

- A list of attributed members that comprise the VIS baseline score
- Individual gaps in care information for each measure in the baseline

Wellness Exam Bonus

Participating Iowa Wellness Plan providers may earn an additional $10 for each Wellness Member exam when at least 50 percent of the assigned Iowa Wellness Plan members have received a Wellness Exam. This voluntary program is aligned with the VIS measures and also supports the member's Healthy Behaviors program that incentives members to seek a wellness exam.

To support implementation of this wellness exam bonus, the Iowa Medicaid Enterprise is allowing a provider to conduct this exam on the same day as a sick visit by using the modifier "25" when submitting the sick visit claim.

Providers will be measured to the 50 percent threshold on patients assigned to the PM for six months or more. The data will be evaluated through a retrospective claims analysis looking at dates of service between "1/1/2014 and 12/31/2014". The IME will conduct this analysis in April and look for the following codes submitted for Iowa Wellness Plan members during the reporting period. For those participating Iowa Wellness Plan providers contracted with Medicaid Wellness ACO, outcomes will be aggregated to the ACO level for payout, but individual outcomes will be also available for providers not participating in an ACO. Wellness Exam bonus money will be paid in April of each year.

E/M CPT Codes and relevant diagnosis codes (Informational Letter No. 1425):
The IME will recognize diagnosis codes **V70.0, V70.5, and V70.9** as payable consistent with the coding conventions of a preventive wellness visit. To bill this service, the appropriate E/M should be billed along with **V70.0, V70.5, or V70.9** as the primary diagnosis, and all diagnosis pointers on the claim lines for the preventive wellness visit date of service should point to the primary diagnosis. The exam is payable to any enrolled provider otherwise qualified to provide this service and consistent with any other applicable program policies.

CPT Codes with a Date of Service Between 1/1/2014 and 12/31/2014	
New Patient CPT Codes	
99385	18-39 years of age
99386	40-64 years of age
Established Patient CPT Codes	
99395	18-39 years of age
99396	40-64 years of age
Evaluation and Management (E/M) CPT Codes Accepted for Preventive Services During the Reporting Period 1/1/2014-12/31/2014	
CPT Code	**Acceptable Diagnosis Codes**
99203	V70.0, V70.5 and V70.9
99204	V70.0, V70.5 and V70.9
99205	V70.0, V70.5 and V70.9
99211	V70.0, V70.5 and V70.9
99212	V70.0, V70.5 and V70.9
99213	V70.0, V70.5 and V70.9
99214	V70.0, V70.5 and V70.9
99215	V70.0, V70.5 and V70.9
Outpatient Hospital Clinic Visits	
G0463	V70.0, V70.5 and V70.9

This policy is intended to encourage member responsibility in proactive management of their own health, balanced with recognition that health care providers know best how to treat their patients. In adjusting the specific direction, the IME has taken into account provider and stakeholder feedback and expanded the scope of E/M CPT Codes that are considered a preventive wellness visit.

Based on clinical guidelines, some individuals between the ages of 22 and 49 would be considered low-risk, requiring a complete annual preventive wellness visit every one to three years. For example, low-risk individuals would ideally visit their physician annually to update their clinical history. This would allow for scheduling a brief visit with their provider that tracks the member's history, age, gender and general health status. This brief visit should include assessment of blood pressure and body mass index (BMI) and any needed labs, but may not require a full physical exam. This type of visit may be completed by nursing staff and would be billed as an E/M code consistent with a nursing visit, which is now reflected in the revised policy.